NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Continuous Glucose Monitors

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Transmitter/ Sensor Name: ☐ Dexcom G5 (Sensor only) ☐ Dexcom G6 ☐ FreeStyle Libre ☐ FreeStyle Libre 2
9 Quantity for Transmitter (G6) _____ (Max 1) 10. Quantity for Dexcom (G5/G6) Sensor _____ (Max 3)
11. Quantity for Reader(Libre/Libre 2) _____ (Max 1) 12. Quantity for Sensors (Libre/ Libre 2) _____ (Max 2)
13. Length of therapy (in days) for Dexcom G6 Transmitter, Decom G5 and G6 Sensor, Libre/Libre 2 Reader and Sensors:
☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other: _____
Max Length of Therapy for Initial Authorization is 180 days
For Dexcom G6 only:
14. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6?
☐ **Yes** ☐ **No** (Answering "NO" indicates that the beneficiary needs the Dexcom Receiver)

Clinical Information

For initial therapy, please answer questions 1-11, (max 6 months authorization):
1. Does the beneficiary have a diagnosis of insulin-dependent diabetes? ☐ **Yes** ☐ **No**
2. Has the beneficiary been using a standard BGM (blood glucose monitor) and testing four (4) or more times daily or using a non-therapeutic CGM? ☐ **Yes** ☐ **No**
3. Does the beneficiary require two (2) or more insulin injections daily? ☐ **Yes** ☐ **No**
4. Does the beneficiary's insulin treatment regimen require frequent adjustment based on standard BGM or non-therapeutic CGM testing? ☐ **Yes** ☐ **No**
5. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? ☐ **Yes** ☐ **No**
6. Has the beneficiary had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one through five (1-5) above have been met, within six months of the initial authorization? ☐ **Yes** ☐ **No**
7. Does the beneficiary use an external insulin pump? ☐ **Yes** ☐ **No**
8. For coverage of Dexcom G5 or G6; is the beneficiary age 2 years or older? ☐ **Yes** ☐ **No**
9. For coverage of FreeStyle Libre is the beneficiary age 18 years or older? ☐ **Yes** ☐ **No**
10. For coverage of FreeStyle Libre 2 is the beneficiary age 4 years or older? ☐ **Yes** ☐ **No**
11. For coverage of FreeStyle Libre, has the beneficiary tried using Dexcom G6? ☐ **Yes** ☐ **No** If no, is there a clinical reason Dexcom G6 could not be used? ☐ **Yes** ☐ **No** If yes, explain _____

For first reauthorization, please answer questions 12-14, (max 12-month authorization) DOCUMENTATION REQUIRED:
12. Has the beneficiary been using the CGM as prescribed? ☐ **Yes** ☐ **No**
13. Has the beneficiary been able to improve glycemic control? ☐ **Yes** ☐ **No**
14. Does the beneficiary continue to use as external insulin pump? ☐ **Yes** ☐ **No**

For Subsequent reauthorizations please answer questions 15-18, (max 12-month authorization) DOCUMENTATION REQUIRED
15. Has the beneficiary had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to submission of this reauthorization request? ☐ **Yes** ☐ **No**
16. Has the beneficiary been using the CGM system as prescribed? ☐ **Yes** ☐ **No**
17. Has the beneficiary been able to maintain or further improve glycemic control? ☐ **Yes** ☐ **No**
18. Does the beneficiary continue to use an external insulin pump? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date:_____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.